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	155704	A. BUILDING _____ B. WING _____	C 05/27/2015

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WALDRON HEALTH AND REHAB CENTER	505 N MAIN ST WALDRON, IN 46182

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F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00171363. Complaint IN00171363-Substantiated. Federal/State deficiencies related to allegations are cited at F 309. Facility number: 000423 Provider number: 155704 AIM number: 100290450 Survey dates: May 19, 20, 21, 22, 26 & 27, 2015 Census bed type: SNF/NF: 71 Total: 71 Census payor type: Medicare: 13 Medicaid: 40 Other: 18 Total: 71 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 3.1.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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by:
Based on observation, interview and record review, the facility failed to implement the abuse policy to protect residents after an allegation of abuse, thoroughly investigate and report an allegation of abuse for 1 of 1 resident who met the criteria for abuse of 3 residents reviewed for abuse (Resident #12).

Findings include:

Interview with Resident #12 on 5/19/15 at 3:21 p.m., indicated a staff member had been abusive to her. The resident indicated she was unsure of the staff members name but thought it was -----. The resident indicated the staff sat her down rough on the bedside commode and she felt like the staff member did it intentional. The resident indicated her bones were brittle and she had a bad back. The resident indicated there were two staff transferring her to the bedside commode and they did not have a gait belt around her waist and was holding her under her arms. The resident indicated it hurt her back and they should have put her down on the bedside commode easy. The resident described the physical appearance of the staff member and the shift she worked. The resident indicated she told the staff member "you hurt me" and the staff member said "I don't have to care for you I can leave you". The resident indicated she did not understand why this staff member did not like her, that she had not done anything to her. The resident indicated she did report it to her daughter but not the staff. The resident indicated the staff member who did it reported it to staff and said it was my fault, but it was not. The resident indicated an older female staff came down and talked to her about the incident. The resident indicated she did not know

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the ladies name that talked with her about the incident. The resident indicated no one had looked at her back to see if she was hurt, but staff had washed her up and did not say anything was wrong to her. The resident indicated she was unsure what day this had happened, but it was recent.

Review of the allegations of abuse for the past 6 months provided by the Administrator on 5/19/15 at 3:50 p.m., indicated no allegations for Resident #12.

Interview with the Administrator on 5/19/15 at 4:00 p.m., indicated he was not aware of any allegations of abuse related to Resident #12. The Administrator indicated there was a remark made by Resident #12 that she had been in a "grumpy mood or something to that effect" and Social Services did a follow up with her. The Administrator indicated he was unsure if there was any documentation of this. Informed the Administrator at this time of Resident #12's allegation of abuse.

Review of the incident report for Resident #12, dated 5/19/15 (no time) indicated the allegation was unsubstantiated. The resident reported of not feeling well and being grumpy over the weekend likely related to a urinary tract infection. There was possible confusion related to the urinary tract infection and may have contributed to the resident blending this allegation with a customer service follow up conducted on 5/18/15, due to a "CNA voicing concern that the resident was impatient with her over the weekend when she was attending to the resident immediately due to waiting on a second on the aide to assist in care". Interview with Resident #12 conducted on 5/18/15

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with the nurse manager and Social Service Director regarding care and satisfaction, the resident did not express concerns with care and made no allegations at that time. There were 11 staff interviews completed that indicated they had not had any concerns with CNA's. None of the staff interviews were with the staff that cared for Resident #12 on dayshift the weekend prior to the allegation of abuse.

Interview with Resident #12 on 5/22/15 at 9:55 a.m., indicated the staff that was abusive to her provided care for her on 5/22/15 at 7:30 a.m. The resident described the staff member's appearance. CNA #2 came into the resident's room to give the resident ice water and the resident pointed to the cna and indicated "that is her". The resident indicated CNA #2 had told her twice that she did not have to care of her and she was going to walk out on her. The call light was pushed for the Administrator to come to the resident's room.

The Administrator came to Resident #12's room on 5/22/15 at 10:08 a.m., and the resident reported to him that CNA #2 was the staff that was rough with her when she put her on the toilet. The resident stated "I don't know what day it was". The Administrator queried do you think the cna's were trying to hurry too much? The resident indicated "yes they are all in a hurry there isn't enough staff". The Administrator queried if the resident had a problem with CNA #2 caring for her and the resident indicated "no as long as she treats me right and does it right I don't care if she takes care of me". The Administrator indicated "you told staff you were grouchy over the weekend" and the resident stated "no I didn't they might of thought I was grouchy but I did not say

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that".

Interview with the Administrator on 5/22/15 at 10:20 a.m., indicated he was taking CNA #2 off the floor while conducting an investigation.

Interview with CNA #2 on 5/22/15 at 10:55 a.m., indicated she had worked with Resident #12 on 5/15/15, 5/16/15 and 5/17/15. CNA #2 indicated the resident had made complaints during care. CNA #2 indicated on 5/17/15 Resident #12 told her she hurt her back when I transferred her to the bedside commode. CNA #2 indicated she told the resident she was sorry and she didn't mean to hurt her. CNA #2 indicated the resident was slipping during the transfer and she was trying to get her sat down before the resident fell. CNA #2 indicated the resident had on house slippers because she doesn't like to wear tennis shoes and she was not utilizing a gait belt during the transfer. CNA #2 indicated it would have been a better transfer if a gait belt had been used. CNA #2 indicated CNA #4 was assisting with the transfer when it happened. CNA #2 indicated she reported the incident to RN #3 on 5/17/15 when the incident happened.

Interview with CNA #4 on 5/22/15 at 11:51 a.m., indicated on 5/17/15 Resident #12 was not in a good mood and didn't feel well. CNA #4 indicated her and CNA #2 was transferring the resident to the bedside commode, the resident had on slippers and they did not use a gait belt during the transfer. CNA #4 indicated the resident began to slip so we hurried and sat her on the toilet. CNA #4 indicated the resident said CNA #2 had hurt her back and she was going to report her. CNA #4 indicated CNA #2 told the resident she did not mean to hurt her and told the resident her name.

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CNA #4 indicated the resident looked at CNA #2 the whole time and she thought the resident was in bad mood. CNA #4 indicated they had reported the incident to RN #3 in front of the resident that they had hurt the resident's back and she was going to report CNA #2. CNA #4 indicated last time she had tried to use a gait belt with the resident she didn't want it. CNA#4 indicated she had never seen staff use a gait belt with the resident except therapy staff and residents act different around therapy.

Interview with RN #3 on 5/22/15 at 11:51 a.m., indicated she was Resident #12's nurse on 5/17/15. RN #3 indicated LPN #5 reported to her that she had heard Resident #12 say "you hurt my back" and then the resident's door shut. RN #3 indicated she went to the resident's room and CNA #2 told her that her and CNA #4 were transferring the resident to the bedside commode and the resident began to slide and they sat her on the toilet and resident said they hurt her back. CNA #2 indicated the resident was going to report them. RN #2 indicated CNA #2 told her she shut the resident's door during the incident because she realized it was open during care. RN #3 indicated she checked the resident's back and there were no bruising, marks or scratches. RN#2 indicated she did not document the assessment or the incident in the resident's record, but had wrote it on a piece of paper for her own records and that LPN #5 had the paper she wrote on. RN #3 indicated the resident did not mention to her the incident and she did not ask the resident about the incident. RN #3 indicated she called the Administrator on 5/17/15 immediately and told him about the incident in case "he may have felt like it was abuse or neglect". RN #3 indicated her and LPN #5 talked to the Administrator on the

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phone on 5/17/15 about the incident. RN #3 indicated the Administrator told her it was not abuse or neglect, did not have her take the CNA's off the floor and did not direct her to make out an incident report.

Interview with LPN #5 on 5/22/15 at 1:15 p.m., indicated on 5/17/15 she heard an elderly female voice come from Resident #12's room say "you hurt my butt" and then heard a younger female voice say " do you think we hurt you on purpose you wouldn't stand up" then the resident's door shut. LPN #5 indicated she went and reported it to RN #3 and she went to the resident's room and instructed me to call the Administrator and tell him what I heard. LPN #5 indicated she called the Administrator and told him what I heard and then handed the phone to RN #3. LPN #5 indicated she did not document the incident in Resident #12's record but had wrote it down on a piece of paper in case there was a question about the incident.

Review of the record of Resident #12 on 5/22/15 at 12:08 p.m., indicated the resident's diagnoses included, but were not limited to, rheumatoid arthritis, chronic kidney disease, diabetes, hypertension, heart disease with heart failure, osteoporosis, closed fracture other specified part of the pelvis and bone and cartilage disorder.

The Admission Minimum Data Set (MDS) assessment for Resident #12 dated, 3/4/15, indicated she was able to make herself understood and she could understand others. The Brief Interview for Mental Status (BIMS) indicated she cognitively intact.

Interview with the Administrator on 5/26/15 at

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1:25 p.m., indicated LPN #5 called him on 5/17/15 regarding another resident and while he was talking to her she said she heard a resident say "you hurt my butt" and she would let RN #3 talk with me because she was the one that went into the resident's room. The Administrator indicated RN #3 told him that the aides told her when they were transferring a resident it hurt the resident's butt. The Administrator indicated RN #3 told him the resident had not said anything to her about the incident and she had checked the resident out and didn't see anything. The Administrator indicated he did not remember a name of the resident being given during the conversation. The Administrator indicated he did not have the nurse send CNA #2 or CNA #4 home on 5/17/15 pending an investigation and did not report the incident to the Indiana State Department of Health, because it was not being seen as allegation of abuse. The Administrator indicated there was not an investigation done on the incident on 5/17/15. The Administrator indicated when RN #3 called him, he felt like it was staff self reporting that a resident said "you hurt my butt" and he was not hearing an allegation and he had asked RN #3 did she see anything wrong and she said "no". The Administrator indicated he did not know why during the investigation for Resident #12 that was conducted on 5/19/15 interviews were not conducted for CNA #2, CNA #4, LPN #5 or RN #3 who were the staff working with the resident prior to the resident's allegations of abuse . The Administrator indicated he did not have any documentation of the incident on 5/17/15 with Resident #12.

Review of the Abuse prevention, intervention, investigation and crime reporting policy provided

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F 226	Continued From page 8 by the Administrator on 5/19/15 at 11:50 a.m., indicated it was the responsibility of employee's to immediately report to the facility Administrator any incident of suspected or alleged neglect or abuse. "Reports shall be thoroughly investigated in a timely manner. "To protect residents and employees from harm or retaliation during an investigating, the facility shall: take prompt measures to remove any resident from immediate harm or danger" " suspend staff member(s) believed to be involved, pending the outcome of an investigation". "The facility Administrator will immediately, or as soon as practically possible within 24 hours an allegation of abuse to the Department of Health Services. 3.1-28(a)	F 226		
F 247 SS=E	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were notified before receiving a new roommate for 4 of 4 residents who met the criteria for transfers. (Residents #3, #47, #70, and #81) Findings included: 1. During an interview, on 5/19/15 at 3:08 p.m., Resident #3 indicated she has had a roommate change in the last 9 months, and the "facility did	F 247		

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not let me know before she moved in." She indicated she had not been given a notice before the change in roommate. No documentation could be found in the clinical record review, on 5/27/15 at 9:55 a.m., that indicated Resident #3 had been notified prior to the change in roommate.

On 5/27/2015 at 12:17 p.m., the Social Service Designee (SSD) indicated Resident #3's roommate was an admission from the community and if they are in the community and admitted they don't receive a notice of a roommate change.

2. During an interview, on 5/19/15 at 1:01 p.m., Resident #47 indicated she has had a new roommate in the past 9 months and that "I didn't have a roommate and they brought her in, no they didn't tell me before."

On 5/27/2015 at 9:24 a.m., Resident #47's record did not indicate a change in roommate, nor that she had received prior notification before the roommate had been moved into her room. In review of her roommate's clinical record on 5/27/15 at 9:45 a.m., for Resident #37 an intrafacility transfer sheet indicated she had been moved into Resident #47's room on 4/1/15 and there was no notation that Resident #47 had been notified prior to the roommate being moved in.

On 5/27/2015 at 12:17 p.m., the SSD indicated she didn't make a progress note because it wasn't a bad situation and Resident #47 didn't get much of a notice; her roommate moved in quickly, she was given notification, then her roommate moved in.

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3. During an interview, on 5/20/15 at 10:56 a.m., Resident #70 indicated she has had a roommate change without a notice before the change, and indicated they just brought her new roommate in and didn't tell her ahead of time. Review of Resident #70's clinical record, on 5/27/14 at 10:10 a.m., failed to indicate she had prior notification that she would receive a new roommate.

On 5/27/2015 at 12:17 p.m., the SSD indicated she couldn't say when she notified Resident #70 of her roommate being moved into her room.

4. During an interview, on 5/20/15 at 10:55 a.m., Resident #81 indicated she had received a new roommate and was not given notice before the change in roommate, that "The staff just brought her stuff in is how I found out." Resident #81's record was reviewed on 5/27/14 at 10:31 a.m. The record failed to indicate she was notified before her new roommate was moved into the room.

During an interview, on 5/27/2015 at 11:00 a.m., the SSD indicated the notification should be in the chart of the person moved into the room and that there is a section on the page where they write that information. The Social Service Designee could not provide any documentation the residents had been notified prior to receiving a new roommate.

During an interview, on 5/27/2015 at 11:10 a.m., the Social Service Designee indicated she verbally notifies them when they are getting a roommate.

During an interview, on 5/27/2015 at 12:17 p.m.,

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F 247	Continued From page 11 the SSD indicated Resident #81 is in a rehabilitation to home room, and the residents are moved in and out quickly; she probably didn't get a notice. A policy for "Room Changes" was provided by the Director of Nurses on 5/27/15 at 1:32 p.m. The policy indicated, but was not limited to, "To ensure residents have compatible roommates and live in a harmonious environment. Process: 1. When a resident requests a room change or a room change is required to promote the resident's health or safety, the SSD will coordinate the room change. 2. The facility will make every effort to ensure the resident is moved into a compatible room. 3. When an appropriate room and roommate(s) have been identified, the SSD will introduce the potential new roommates to one another...7. The SSD will make follow up visits to review the outcome of the visit and document the findings...."	F 247		
F 258 SS=D	3.1-3(v)(2) 483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interviews the facility failed to ensure comfortable sound levels for 2 of 28 residents who fit the criteria for sound levels. (Resident #68 and #121)	F 258		

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Findings include:

1. During an interview on 5/19/2015 at 2:23 p.m., Resident #68 indicated it was noisy sometimes, she didn't know what time, but there are kids left out in the hallway; her husband thinks its visitors. Resident #68 indicated she has complained to staff about it.

During an interview on 5/27/2015 at 9:51 a.m., Resident #68 indicated something rolls up and down the hall and makes a lot of noise and someone yells part of the night every night. She said someone brings in children and they run up and down the hall. She indicated the man yelling keeps her awake at times but she said she takes a sleeping pill and the children haven't been in for awhile but they were coming in every day for awhile. A cart with noisy wheels was heard being rolled down the hallway and when observed, a tall linen cart was being rolled down the hall

2. During an interview on 5/20/15 at 10:38 a.m., Resident #121 indicated a man in her hallway hollers all night and she has been kept awake for the past three nights. She indicated she told staff this morning. She said he "hollers" out two names and she doesn't know who he is, that staff go down with him and talk with him and she is "wore out from lack of sleep." She indicated she has asked to move this morning so she can get some rest. She thought she had spoken to the Social Services Designee but wasn't sure.

During an interview, on 5/27/15 at 10:06 a.m., Resident #121 indicated a male resident hollers from 7:00 p.m. through most of the night. She said "I hate to say anything because I may be that way one day, but it eats your nerves, and I

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F 258	Continued From page 13 haven't slept for 3 nights. I haven't sleep very well, I sleep off and on to get any sleep." She said she doesn't like to shut her door because her roommate needs things during the night. She sleeps later in the day too, one day she didn't get up until 1:00 p.m., because she was "worn out".	F 258		
F 309 SS=D	3.1-19(f) 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: A. 1.) Based on interview and record review, the facility failed to obtain physician orders for tracheotomy (artificial airway through the neck into the trachea) care, assess the tracheotomy and failed to document emergency equipment necessary for a resident with a tracheotomy was located at the bedside for 1 of 3 residents reviewed for death (Resident #A). A. 2) Based on observation, interview and record review, the facility failed to thoroughly assess and document bruising for 1 of 3 residents reviewed for non pressure skin conditions of 10 residents who met the criteria for non pressure skin conditions (Resident #7).	F 309		

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Findings include:

A. 1.) Review of the record of Resident #A on 5/21/15 at 10:00 a.m., indicated the resident's diagnoses included, but were not limited to, acute respiratory failure following trauma and surgery, hypertension, anxiety, depression, acute pain due to trauma, urinary retention, C 1-C 4 level with central cord syndrome (acute spinal cord injury), syncope, mild intellectual disability, and mild cognitive impairment.

The record of Resident #A indicated he was admitted to the facility on 12/12/14.

The provisional notification of death burial transit permit for Resident #A was dated 12/13/14.

The history and physical progress note from a major medical hospital for Resident #A, dated 9/16/14, indicated the resident had fell and had extensive injuries including, but not limited to, central cord syndrome, cervical stenosis C 2 -T 1 laminectomy (surgical procedure that removed a portion of the vertebrae bone) and partial quadriplegia (partial loss of the use of limbs). The resident had tracheostomy (trach) on 9/8/14 and was to be weaned from a ventilator.

The admission nursing assessment for Resident #A, dated 12/12/14 at 3:10 p.m., indicated the resident was admitted to the facility according to resident/POA was to help the resident get better. The resident reason for admission according to the paperwork was trach care, G-tube feeding (artificial nutrition directly into the stomach via a tube) and total care for Activities of Daily Living (ADL's). The resident was difficult being understood related to a trach.

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The progress note for Resident #A, dated 12/13/14 at 8:57 a.m., indicated the floor nurse was in the resident's room around 7:30 a.m., and the resident's vital signs were blood pressure-110/64, pulse-68, respirations-18. The Occupational Therapist (OT) entered the resident's room at 8:30 a.m., and the resident was unresponsive, cold to the touch and the OT was unable to see respirations from the resident. The resident's nurse came into the room and the resident had no pulse and Cardiopulmonary Resuscitation (CPR) was initiated. The emergency personnel was called at 8:35 a.m. The resident was lowered to the floor and CPR was continued. Oxygen was on the trach as ordered. "Suction was next to the bedside directly after the resident was lowered to the floor suction was performed through the trach stoma", "no secretions were present". The resident's mouth was opened and lips purple "no copious" amounts of secretions to the back of the throat. "CPR continued with with alternating staff." The medics arrived at 8:40 a.m., and administered two rounds of EPI (epinephrine) and there was no response from the resident. The medic called the Medical Doctor (MD) and the reported the resident's condition and the resident was pronounced deceased at 8:59 a.m. The progress note was electronically signed by RN #11.

Interview with the Director Of Nursing (DON) on 5/22/15 at 2:45 p.m., indicated the facility used the Medication Administration Record (MAR) and physician recapitulation (recaps) from the transferring facility as admission orders for Resident #A when he was admitted to the facility.

Review of Resident #A's documentation from the

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transferring facility indicated the ventilator was discontinued on 11/12/14.

Interview with the DON on 5/26/15 at 1:20 p.m., indicated there was no assessment of Resident #A's trach including, but not limited to, the size and the type of trach it was. The DON indicated there was no physician orders for care of the trach besides to change it monthly and as needed. The DON indicated there no physician order for oxygen or suctioning for Resident #A. The DON indicated there was no documentation that the resident was suctioned prior to his death. The DON indicated there were no oxygen saturations done on the resident.

Interview with RN #1 on 5/26/15 at 2:20 p.m., indicated she was the admission nurse for Resident #A. RN #1 indicated she could not remember what type of trach the resident had, if he had oxygen, a suctioning machine at bedside or an emergency trach at bedside.

Interview with the DON on 5/26/15 at 3:55 p.m., indicated Resident #A did not have a plan of care for his trach. The DON indicated the facility used a "order set" for residents admitted with trach's, but the order set was not used for Resident #A. The DON provided the order set and it indicated "care tracheostomy orders". The airway orders included the following: trach tube type, size, aerosol mist to trach via trach mask, suction trach every shift and as needed, check oxygen saturation every shift an as needed, asses breath sounds every shift and as needed, change trach tube every month and as needed, change trach tube corrugated hose and mask every week and as needed, licensed nurse may re-insert trach tube as needed for accidental extubation or

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dislodgement. The trach care orders included, trach site care every shift and as needed, if disposable inner cannula-change disposable inner cannula every day and as needed, in non-disposable inner cannula- clean inner cannula at least every day and as needed, oral care every shift, change tracheostomy tie every week and as needed, change suction tubing every week and as needed, observe trach site/stoma for redness, bleeding, swelling, increased secretions, purulence and skin breakdown every shift.

The "tracheostomy care" policy provided by the DON on 5/27/15 at 9:35 a.m., indicated "tracheostomy care will be performed per physician's order, in a safe and effective manner to maintain a clean stoma site, prevent infection or skin breakdown, maintain a patent airway and promote resident comfort." The assessment guidelines included, but were not limited to, breathing patterns, changes in skin integrity at stoma site and change in mental status. The care plan documentation guidelines were to identify the underlining problem for the tracheotomy. The goal's were to identify measurable goal for maintaining the trach, identify measurable goals for preventing infection and list approaches to monitor and prevent complication.

The routine tracheostomy care and tracheostomy tube change policy provided by the DON on 5/27/15 at 5:15 p.m., indicated the purpose was to provide the resident with a patent airway at all time, observe for irritation beneath tracheostomy tube or ties and prevent respiratory infection. The tracheostomy is performed to provide an airway because the upper airway is inadequate, help remove tracheotomy secretions, prevent

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aspiration of pulmonary secretions, food and/or fluids into the lungs and provide a patent airway. The objective was to keep incision area clean and free of infection, maintain a patients airway and prevent respiratory infection. The policy indicated an emergency tracheostomy reinsertion supplies should be available at the bedside at all times. The tracheostomy cuff should remain deflated at all times unless the physician ordered for a nurse to inflate the cuff with air. Trach tubes with inner cannula's should have the cannula removed and cleaned at least every 8 hours.
A.2. Resident #7 was observed on 5/19/15 at 12:59 p.m., with purplish discoloration on top of both hands and scattered purplish areas of discoloration on both arms. She indicated she had smashed her right hand in the hallway.

Resident #7's record was reviewed on 5/21/15 at 3:37 p.m. She was admitted to the facility 4/17/15. Her diagnoses included but were not limited to chronic kidney disease, peripheral vascular disease, diabetes mellitus, and hemiplegia affecting her non-dominant side.

An "Admission Nursing Assessment" for Resident #7 dated 4/17/15, indicated the following measurements for areas of bruising: Right antecubital-1 cm (centimeter) long by 3.5 cm wide; right upper arm-3.5 cm long by 1 cm wide; right lower arm-.05 cm long by .05 cm wide; right wrist-3 cm long by 2 cm wide; right hand-1 cm long by 1 cm wide; right wrist-1 cm long by .05 cm wide; right wrist-.05 cm long by .05 cm wide; back of left arm-3 cm long by 1 cm wide; left upper arm-2 cm long by 1 cm wide; left upper arm-1 cm long by 1 cm wide; left upper arm -1 cm long by 1.5 cm wide and 2 cm long by 1.5 cm wide; left antecubital-2 cm long by 2 cm wide; left

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lower arm-3 cm long by 2 cm wide, 2 cm long by 1 cm wide, 5 cm long by 1 cm wide and 2.5 cm long by 1 cm wide; top of left hand-7 cm long by 5 cm wide; left wrist 3 cm long by 1 cm wide; top of left hand 3 cm long by .02 cm wide and 3 cm long and 2 cm wide; right leg-9 cm long by 6 cm wide; left upper leg-.05 cm long by .05 cm wide; discoloration below left lower knee-3 cm long by 4 cm wide.

Interventions for Resident #7 initiated "04/20/15" on her "Potential for Impaired Skin Integrity and Bruising" plan of care, indicated her skin would be evaluated weekly and she would be encouraged to wear long sleeves to protect her arms because she bruised easily related to receiving Coumadin therapy.

Resident #7's Admission Minimum Data Set (MDS) assessment dated 4/25/15, indicated she was understood and had the ability to understand others. She was cognitively intact for her daily decision making skills.

A "Skin Inspection Assessment" for Resident #7 dated 4/30/15, indicated "no noted areas to skin."

A "Skin Inspection Assessment" for Resident #7 dated 5/7/15, indicated "no noted areas to skin."

A "Skin Inspection Assessment" for Resident #7 dated 5/14/15, indicated "bruises remain noted on admission."

An interview with the Director of Nursing (DON) on 5/22/15 at 10:04 a.m., indicated the facility utilized a Skin Inspection Assessment that allowed nursing staff to document a thorough skin assessment.

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F 309	Continued From page 20 On 5/22/15 at 3:52 p.m., Resident #7 was observed to have purplish discoloration on top of both hands. The purplish discoloration covered most of the top of her right hand and near the top of her fingers. The purplish discoloration on top of her left hand was approximately the size of a quarter and a small area on her wrist. Both of her arms had scattered areas of discoloration. She indicated she had bruises on her legs. The "Skin Integrity Standard" procedure provided by the DON on 5/27/15 at 2:30 p.m., indicated the following: ... "Comprehensive "head to toe" assessment of all patients by licensed nurse conducted weekly. Documentation must include: description of skin tissue, color, turgor, rashes, bruising, skin tears, edema, incision lines, access lines, devices and any other skin related issue...." This federal tag relates to Complaint IN00171363.	F 309		
F 311 SS=D	3.1-37(a) 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide passive range of motion (PROM) services to maintain functional joint mobility for 1 of 3 residents reviewed for rehabilitation of 14 who met the criteria for	F 311		

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rehabilitation.

Findings include:

An interview with RN #6 on 5/22/15 at 3:01 p.m., indicated Resident #82 received PROM to her upper and lower extremities 6-7 days a week for a FMP (Functional Maintenance Program). She indicated she had developed the FMP and initiated the program plan on 5/19/15. After reviewing the documentation in her computer she indicated no PROM exercises had been documented for Resident #82 since she had initiated the plan.

Resident #82's record was reviewed on 5/22/15 at 4:01 p.m. Diagnoses included but were not limited to Alzheimer disease and depression.

Resident #82's Admission Minimum Data Set (MDS) assessment dated 3/26/15, indicated she was understood and had the ability to understand others. She required extensive assistance of 1 person for bed mobility, transferring, to walk in her room, dressing, eating, toileting, and personal hygiene.

A "PT - Therapist Progress and Discharge Summary" for Resident #82 dated 4/28/15, indicated "... pt (patient) has shown a significant decline in medical status and unable to tolerate and participate in therapy at this time... pt is dependent on all functional mobility task... Discharge planned for this patient. Recommendations discussed with patient and/or caregivers include cont (continue) FMP (Functional Maintenance Program)."

Resident #82's Significant MDS assessment

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F 311	Continued From page 22 dated 4/29/15, indicated she was moderately impaired for her daily decision making skills. She required extensive assistance of 1 person for bed mobility and eating. She required extensive assistance of 2 persons for transferring, toileting, and personal hygiene. She required total assistance of 1 person for dressing, and she did not walk. An "At risk for contractures in upper and lower extremities related to decreased mobility" plan of care for Resident #82, initiated on 5/19/15, indicated she would receive "PROM to bilateral shoulders, elbows, wrists, knees, and ankles 20 reps (repetitions) each 6-7 days per week." On 5/22/15 at 3:42 p.m., Resident #82 was observed lying in bed. Her bed was positioned low to the floor and a mat was on the floor next to her bed. When requested, Resident #82 extended her fingers on both hands from a fist position. When the surveyor provided her name, Resident #82 stated "mine is to." On 5/26/15 at 10:38 a.m., CNA #7 indicated a FMP was not documented in the computer for Resident #82. On 5/26/15 at 10:39 a.m., Restorative Aide #8 indicated a FMP was not documented in the computer for Resident #82.	F 311		
F 323 SS=D	3.1-38(a)(2)(A)(B)(C) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure a resident, with a history of wandering into other resident rooms at night, was adequately supervised, and the resident was found in bed with a female resident (Resident #53). The facility also failed to ensure a resident was safely transferred with a gait belt and wore appropriate foot wear, resulting in the resident experiencing back pain (Resident #12). This affected 2 of 3 residents reviewed for supervision to prevent accidents.

Findings include:

1. A copy of an incident that had been reported to the Indiana State Department of Health, was provided by the Administrator on 5/19/15 at 11:00 a.m. The incident indicated, on 5/19/13 at 12:09 a.m., "...CNA heard female resident [room number] who was last checked at 11:30 p.m., make a noise. CNA entered room for bed check and found this resident (Resident #53) nude lying in bed of female resident who was dressed in brief, gown, with pillow between knees facing wall. Type of Injury: None. Immediate Action Taken: This resident removed immediately from room (room number) Returned to his own room and assisted to bed. ED (Executive Director), family and physician notified. Both residents assessed with no findings. Preventative measures taken: Increased supervision, referred to geri-psych clinician. Paxil med dose will be increased to prior level after unsuccessful GDR

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(Gradual Dose Reduction). Will remain under increased supervision until cleared by psychologist."

Resident #53's record was reviewed on 5/21/2015 at 10:27 a.m. The record indicated Resident #53 was admitted on 8/22/14, with diagnosis that included, but were not limited to, dementia with behavioral disturbance, generalized muscle weakness, altered mental status, debility, cerebrovascular disease, speech or language disorder, gait abnormality, falls, cognitive deficits due to cerebrovascular disease, depression, adult failure to thrive, atrial fibrillation, esophageal reflux, osteoporosis, chronic airway obstruction, and high blood pressure. A diagnosis of problems related to high-risk sexual behavior was added on 5/19/15.

A quarterly Minimum Data Set assessment, dated 4/13/15, indicated Resident #53 had moderate difficulty with hearing; the speaker has to increase his/her volume and speak distinctly, his speech is clear, makes self understood, usually understands others, is moderately impaired, decisions poor, cues/supervision required in cognitive skills for daily decisionmaking, requires supervision of one person physical assist for transfers, requires extensive assist of one for walking, is independent for locomotion in his wheel/chair after set up, and his balance is unsteady; is only able to do with human assistance.

Nurse's notes dated 8/23/14 at 7:22 a.m. indicated: "Resident inappropriately reaching/touching CNA legs during AM care. CNA states during peri-care resident stated "I bet you want some of that." CNA notified this writer.

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Action: Resident notified that it is inappropriate to talk that way to staff and to touch legs/buttocks of staff. Response: Resident shakes head yes."

Nurse's notes dated 8/28/14 at 2:48 a.m. indicated: "Found resident in hallway with cane walking into room [number]. Stopped resident from entering room. Showed resident where his room was. He stated "there are 19 people living in my house I don't like". Walked back towards his room and then he tried to enter room [number]. Directed resident again towards his room. "You mean I have to share my bedroom with someone. I don't like this at all. I'm leaving this place in the morning." Resident now sitting in chair near nurses station tapping cane on floor. Action: Response: Monitor closely to prevent him from entering other resident rooms."

Nurse's notes dated 9/19/14 at 4:01 a.m., indicated: "This writer was walking down south hallway to find this resident wheeling himself out of Room [number]. Action: Asked resident not to go into other resident rooms. Response: No reply."

Nurse's notes dated 9/19/14 at 3:13 p.m., indicated: "Reported by OTA (Occupational Therapy Assistant) that this resident asked her if she wanted to have sex with him. Action: Nurse spoke with resident about inappropriate comments and resident states: "I know". Response: Will continue to monitor."

Nurse's notes dated 9/19/14 at 8:28 p.m., indicated: "Resident has had an increase in sexually inappropriate behaviors such as asking staff members to "make love" with him. Resident has also been noted to wander into other

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resident's rooms during the night. Action: Writer spoke with [Psychologist] and NP (Nurse Practitioner) on this date regarding resident's behaviors. Writer did go over interventions of taking resident to the lobby area when awake at night to help monitor, as well as situations when resident would possibly need to be sent out to a psych hospital if behaviors are unable to be controlled and are affecting other residents. Response: Writer spoke with nursing staff and ED regarding interventions and plan to help with behaviors over the weekend."

Nurse's notes dated 11/3/14 at 8:55 a.m., indicated: "Resident will be seen by [Psychologist] on this date for psychotherapy. Action: Resident has exhibited no behaviors or changes in mood/psychosocial well being. Resident continues to eat meals in the main dining room with other residents and attends activities of interest. Response: Progress note to follow."

Nurse's notes dated 11/8/14 at 5:32 a.m., indicated: "Resident up in w/c (wheel chair) until 9pm. Then back up again at 1am and was rummaging through linen closet. Then up again at 3am to MDR (main dining room) and when staff went to check that resident has returned to his room, Resident was seen leaving room [number]. Resident escorted back to his room and assisted back to bed. Action: Response: Cont to monitor."

Nurse's notes dated 4/1/15 at 4:59 a.m., indicated: "CNA assisting w/am (with morning) care and resident stated "Why don't you climb in bed w(with)/me. You'll enjoy it" Action: Reminded resident that was inappropriate

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behavior. Response: Cont[inue] to monitor."

Nurse's notes dated 5/19/15 at 12:09 a.m., indicated: "Res found in another female resident's bed while she was in it w/clothes off. Action: Res reminded that he needed to be in his own room, in his own bed and that female resident was not his wife. CNA assisted res 2/dressing and returned him to his own room. Response: Attempted to notify E.D., [E.D.'s name] of incident, message left."

A Psych Consultation, dated 5/19/15, indicated: "Saw Pt. (patient) for follow up secondary to an event occurring earlier in the day in which a CNA found patient in another female patient's room laying in bed without clothing with this 2nd female resident. Patient was redirected out of the room without incident, reminded by staff that this was not his room, the female staff member not his wife. Patient had done far better with this issue, no incidents of reported sexual inappropriateness while taking Paxil at 20 mg/ po qd. GDR (Gradual Dose Reduction) efforts were initiated, the patient returning to previous behavioral patterns soon thereafter. Pt. did not wish to discuss the events similarly transpiring with unsupervision. I get the sense that he remembers parts at least of what he did and may be embarrassed by his behavior. I am recommending: 1) Return Paxil to 20 mg/po qd, diagnosis sexual inappropriateness. 2) Please consider recent Paxil reduction efforts a failed gradual dosage reduction. 3) Follow up as appropriate."

A care plan with a start date of 9/3/14, and a revised date of 5/19/15, indicated: "Resident has episodes of sexually inappropriate behaviors.

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5/19/15 - Resident was noted to get in bed with a female resident. Goal: Resident's episodes of inappropriate behavior will decrease to no more than one time per month. Interventions/Tasks: (5/19/15) increased supervision for 7 days if no further sexual behavior noted. Be non-judgmental when confronting negative behaviors. Detour resident from the situation. Meds as ordered. Refer to psychology as needed. Separate resident from peers if resident's sexual behavior becomes offensive and is directed towards other residents. Tell resident calmly and firmly that this behavior is not acceptable whenever it occurs."

A care plan, with a start date of 9/3/14, indicated a problem of: "Resident has behaviors of wandering at night into others rooms. Goal: The resident will not wander into others rooms through next review. Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Bring resident to main dining room where activities can be provided. Help resident find his room when attempting to enter others rooms. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Offer resident to come to main dining room when wandering and offer coffee. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes as needed. Speech to eval and treat."

A care plan, with a start date of 4/21/14, indicated a problem of: "The resident has impaired cognitive function/dementia or impaired thought

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processes r/t (related to) short term memory loss, long term memory loss", and was updated on 1/22/15 to include: "Resident gets more confused in the afternoon and may begin looking for deceased wife." Goal: "The resident will improve current level of cognitive function through the review date. Interventions: Cue, reorient and supervise as needed. Encourage resident to participate in mentally stimulating activities. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Provide mental stimulation during conversation and care. Talk with resident about time of day, day of week, and task at hand. Use task segmentation to support short term memory deficits. Break tasks into one step at a time."

A care plan with a start date of 11/13/14 and revised on 5/20/14, indicated a Problem of: "The resident uses antidepressant medication r/t sexually inappropriate behaviors and insomnia. Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Interventions: Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness Q (every)-shift. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of antidepressant. Monitor/document/report PRN adverse reactions to antidepressant therapy: change in behavior/ mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls;

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dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v (nausea/vomiting), dry mouth, dry eyes."

A care plan with a start date of 11/13/14, indicated a problem of "Psychotropic medications r/t behavior management. Goal: The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date." Interventions included side effects, pharmacy reviews, and education to the resident/family/caregivers.

A care plan, with a start date of 11/13/14, indicated a problem of: "Sleep disturbance manifested by signs and symptoms of insomnia related to: cannot stay asleep at night. Goal: to reduce or eliminate sleep pattern disturbance each NOC (night) X (times) 90 days. Interventions: Provide a darkened environment at night. Provide calm, quiet environment. Discourage evening caffeine intake after 6pm. Assist resident to obtain comfortable position PRN (as needed). Provide adequate pillow and blankets as desired to meet personal comfort level. Offer evening /HS snack. Attempt to identify reason(s) for sleeplessness and address underlying cause if identified prior to Rx (prescription) use, which may include: 1. Pain, 2. Noise 3. hunger or thirst 4. Positioning 5. Anxiousness 6. worry 7. Depression 8. Medical symptoms. Medications as ordered: monitor sleep patterns, evaluate medication use quarterly for least effective dose, therapeutic effects, and that actual or intended benefit justifies risk of use...." Side effects of his antidepressant were included in the care plan.

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Interdisciplinary Team notes, dated 5/19/15, indicated "Increase Paxil, 30 min checks from 7pm to 7 am, [Psychologist] to follow up".

Current physician's orders included, but were not limited to: Depakote 125 milligrams (mg) by mouth every morning for dementia with behavioral disturbances (started 1/29/15), Trazodone 50 mg by mouth every day at bedtime for depression (started 1/14/15), and Paxil 20 mg by mouth every day had been increased on 5/19/15.

During an interview, on 5/22/2015 at 2:30 p.m., the Director of Nursing (DON) indicated they are doing 30 minute and 15 minute checks and the sheets are at the nurse's station. An observation of these sheets indicated staff initial and sign where the resident's location is every 15 minutes.

During an interview, on 5/22/2015 at 3:01 p.m., the DON indicated Resident #53 had never had any sexual comments towards other residents and the psychologist came in and did a progress note on both residents. She indicated both residents have dementia.

During an interview, on 5/22/2015 at 3:08 p.m., the Administrator indicated that when the nurse called him, to make notification, she described the CNA had gone into the room, after she heard the resident make a sound, to check on her. Resident #53 was on [Resident #52's] bed, lying next to her and her clothing, pillow, and brief were all intact. The nurse thought the CNA had gone in just after Resident #53 had walked in, they got him up and into his wheelchair and took him to his room. They were able to direct him back into

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bed without any difficulty. The Administrator indicated he had also spoken to the CNA and she gave him the same information. The CNA emphasized that he was laying in bed with his back to her, and said he had just gone in there. She said he is up and down all through the night, but not in the female resident's room. She told him they got him up in his wheelchair and got him back to his room, it didn't look like any contact had been made between them. When Resident #53 first came in, he wandered throughout the facility, he was resistive to having a roommate, and was not as warm and friendly as he is in most cases now. He is monitored with a daytime and a nighttime watch schedule, staff has been made aware to keep an eye on Resident #53 wherever he is. He was reviewed for medications and had a medication reduction. When he first came in his sexual interests were directed towards the staff.

During an interview, on 5/22/2015 at 9:37 p.m., LPN #10 indicated she was here that Monday night when Resident #53 was found in the female resident's bed, but did not see it, the CNA did and now they monitor him by 15 minute checks and documents it on a form. She said she has not observed him in anyone's room since then.

During an interview, on 5/22/2015 at 9:45 p.m., CNA #11 indicated on 5/19/15, she was taking care of another resident and had to go to the cabinet for linens. She heard Resident #52 make a noise and went in her room and found Resident #53 on top of Resident #52's bedcovers. She indicated Resident #52 was hollering out saying things. CNA #11 told him that was not his wife, this was not his room, and she took him back to his room. She told the nurse and the nurse

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checked on them, and CNA #11 kept an eye on him the rest of the shift and there were no more incidents.
2.) Interview with Resident #12 on 5/19/15 at 3:21 p.m., indicated the staff sat her down rough on the bedside commode. The resident indicated her bones were brittle and she had a bad back. The resident indicated there were two staff transferring her to the bedside commode and they did not have a gait belt around her waist and was holding her under her arms. The resident indicated the transfer caused her back to hurt. The resident indicated she was unsure what day this incident occurred.

Interview with CNA #2 on 5/22/15 at 10:55 a.m., indicated on 5/17/15 Resident #12 told her, she hurt her back during a transfer to the bedside commode. CNA #2 indicated the resident was slipping during the transfer and she was trying to get her sat down before the resident fell. CNA #2 indicated the resident had on house slippers because she doesn't like to wear tennis shoes and she was not utilizing a gait belt during the transfer. CNA #2 indicated it would have been a better transfer if I had used a gait belt. CNA #2 indicated CNA #4 was assisting with the transfer when it happened.

Interview with CNA #4 on 5/22/15 at 11:51 a.m., indicated on 5/17/15 her and CNA #2 was transferring Resident #12 to the bedside commode, the resident had on slippers and they did not use a gait belt. CNA #4 indicated the resident began to slip so we hurried and sat her on the toilet. CNA #4 indicated the resident indicated the transfer hurt her back. CNA #4 indicated the last time she had tried to use a gait belt with the resident she didn't want it. CNA#4

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indicated she had never seen staff use a gait belt with the resident except therapy staff and residents act different around therapy.

Review of the record of Resident #12 on 5/22/15 at 12:08 p.m., indicated the resident's diagnoses included, but were not limited to, rheumatoid arthritis, chronic kidney disease, diabetes, hypertension, heart disease with heart failure, osteoporosis, closed fracture other specified part of the pelvis and bone and cartilage disorder.

The fall risk assessment for Resident #12 dated, 2/25/15 indicated the resident was at high risk for falls.

The Admission Minimum Data Set (MDS) assessment for Resident #12 dated, 3/4/15, indicated she was able to make herself understood and she could understand others. The Brief Interview for Mental Status (BIMS) indicated she cognitively intact, she required extensive assistance of two staff to transfer and use the bathroom.

Interview with Resident #12 on 5/26/15 at 9:42 a.m., "no don't mind if the staff use a gaitbelt when transferring me", the resident stated "the aides do not use a gait belt, only therapy staff do."

Observation on 5/26/15 at 11:00 a.m., CNA #9 and CNA #10 transferred Resident #12 from the bed to the wheelchair with a gait belt. CNA asked the resident if she wanted slippers or tennis shoes and the resident chose her tennis shoes. The resident voiced no complaints about the use of the gait belt.

The fall management policy provided by the

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F 323	Continued From page 35 Director Of Nursing (DON) on 5/22/15 at 11:50 a.m., indicated the purpose was to evaluate risk factors and provide interventions to minimize risk, injury, and occurrences. Equipment for fall prevention included, but were not limited to, adaptive equipment. The gait belt policy provided by the DON on 5/26/15 at 3:55 p.m., indicated it was "the policy of this facility that staff will help control and balance (by using a gait belt) residents who require assistance with ambulation and transfer". The purpose was to help control and balance resident during assisted transfer or ambulation. "Apply gait belt to resident waist unless otherwise indicated" "After the resident is standing, the belt assists in stabilizing, turning and walking the resident." 3.1-45(a)(1)	F 323		
F 514 SS=D	3.1-45(a)(1) 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to document a resident received physician's ordered nutritional supplements for 1 of 3 residents reviewed for nutrition of 6 who met the criteria for nutrition.

Findings include:

Resident #114's record was reviewed on 5/26/15 at 11:30 a.m. He was admitted to the facility on 3/11/15. His diagnoses included but were not limited to diabetes mellitus and renal failure.

A physician's order for Resident #114 dated 3/11/15, indicated he would receive a regular textured diet and regular thin consistency liquids. His documented admission weight indicated 149.4 pounds.

Local hospital laboratory values for Resident #114 dated 3/13/15, indicated a low albumin level of 3.1 and a low total protein level of 6.3.

Resident #114's Admission Minimum Data (MDS) assessment dated 3/18/15, indicated he had no dental problems and required extensive assistance of 1 person to eat.

Resident #114's continued weight documentation indicted the following: 3/23/15-144.7 pounds, 3/30/15-143.8 pounds, 4/4/15-142 pounds, and 4/6/15-140 pounds. The weight documentation indicated he had lost a total of 9.4 pounds since admission.

A physician's order for Resident #114 dated

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F 514	Continued From page 37 4/7/15, indicated he would receive 120 ml (milliliter) healthshake 2 times a day. A "Healthshake" was initiated on Resident #114's Nutrition and Hydration Plan of Care "04/08/2015." An interview with the Director of Nursing on 5/27/15 at 1:51 p.m., indicated no documentation was available Resident #114 received his physician ordered healthshake's. She indicated the physician's order should have been entered in the computer as to allow nursing staff to document the percentage of healthshake Resident #114 had consumed each time and wasn't. 3.1-50(a)(1)	F 514		